Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
FACILITY INSURANCE CORPORATION

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-1895-01

MFDR Date Received
February 10, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility $30,370.20 for the MAR at 200%. Based on their payment of $28,065.22, a supplemental payment of $2,304.98 is due."

Amount in Dispute: $2,304.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier determined the correct reimbursement rate was $28,065.22… The carrier submits that all fee reductions were made in accordance with the applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 17, 2010 to May 18, 2010	Outpatient Hospital Services	$2,304.98	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §133.4 requires written notification to health care providers of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider.
4. Texas Labor Code §413.011(d-3) specifies the contract information that shall be provided on Division request.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 111-001 – COVENTRY CONTRACT STATUS INDICATOR 01 – CONTRACTED PROVIDER
   - 595-001 – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.
   - 595-004 – THE ALLOWANCE FOR THIS LINE HAS BEEN SUMMED WITH OTHER ALLOWANCES ON THE BILL AND RE-DISTRIBUTED EVENLY.
   - 850-100 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. UMD RECOMMENDS $1,910.00
   - 851-001 – PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION. UMD RECOMMENDS $0.00
   - 857-001 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE. INCLUDED IN GLOBAL REIMBURSEMENT. UMD RECOMMENDS $0.00
   - 901 – RECONSIDERATION NO ADDITIONAL PAYMENT. ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 903 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. UMD RECOMMENDS

Issues

1. Is the insurance carrier's denial of procedure code 63650 supported?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services billed under procedure code 63650 with reason code 851-001 – "PAYMENT DENIED/REDUCED FOR EXCEEDED PRECERTIFICATION/AUTHORIZATION. UMD RECOMMENDS $0.00." 28 Texas Administrative Code §134.600(b), effective May 2, 2006, 31 TexReg 3566; states, in pertinent part, that "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services…" Review of the submitted information finds no documentation to support that the provider obtained preauthorization for the disputed services prior to providing the health care, or that the services were provided in response to an emergency. This denial code is supported. Reimbursement for procedure code 63650 is not recommended.
2. The insurance carrier reduced or denied disputed services with reason code 111-001 – "COVENTRY CONTRACT STATUS INDICATOR 01 – CONTRACTED PROVIDER" Review of the submitted information found insufficient evidence to support that the services in dispute are subject to a contracted fee arrangement. 28 Texas Administrative Code §133.307(e)(1) states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." Texas Labor Code §413.011(d-3) requires, in pertinent part, that "An insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. . . . For medical fee disputes that arise regarding non-network and out-of-network care, the division may request that copies of each contract under which fees are being paid be submitted to the division for review." On March 15, 2011, the Division requested the respondent to provide a copy of the referenced network contract and documentation to support provider notification as required under 28 Texas Administrative Code §133.4. The respondent did not submit copies of the requested information. The above denial/reduction reason is not supported. Pursuant to Texas Labor Code §413.011(d-3), which states, in pertinent part, that "the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract: (1) is not provided in a timely manner to the division on the division's request," the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines..
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published

annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code C1778 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code C1787 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code C1820 has a status indicator of N , which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code 88300 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0433, which, per OPPS Addendum A, has a payment rate of $16.73. This amount multiplied by 60% yields an unadjusted labor-related amount of $10.04. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of $8.92. The non-labor related portion is 40% of the APC rate or $6.69. The sum of the labor and non-labor related amounts is $15.61. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $15.61. This amount multiplied by 200% yields a MAR of $31.22.
   - Procedure code 77003 has a status indicator of N , which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Procedure code 63685 has a status indicator of S , which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0039, which, per OPPS Addendum A, has a payment rate of $13,892.45. This amount multiplied by 60% yields an unadjusted labor-related amount of $8,335.47. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of $7,404.40. The non-labor related portion is 40% of the APC rate or $5,556.98. The sum of the labor and non-labor related amounts is $12,961.38. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.152. This ratio multiplied by the billed charge of $26,791.00 yields a cost of $4,072.23. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $12,961.38 divided by the sum of all APC payments is 99.11%. The sum of all packaged costs is $13,391.52. The allocated portion of packaged costs is $13,272.50. This amount added to the service cost yields a total cost of $17,344.73. The cost of this service exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers, is $12,961.38. This amount multiplied by 200% yields a MAR of $25,922.76.
   - The insurance carrier denied procedure code 63650 for exceeding preauthorization. As stated above, this denial reason is supported. Payment is not recommended.
   - Procedure code 95971 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0692, which, per OPPS Addendum A, has a payment rate of $107.85. This amount multiplied by 60% yields an unadjusted labor-related amount of $64.71. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of $57.48. The non-labor related portion is 40% of the APC rate or $43.14. The sum of the labor and non-labor related amounts is $100.62. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $100.62. This amount multiplied by 200% yields a MAR of $201.24.

- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2710 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J2765 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code Q9966 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

5. The total recommended payment for the services in dispute is $26,155.22. This amount less the amount previously paid by the insurance carrier of $28,065.22 leaves an amount due to the requestor of $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	September 7, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.